# Adolescent School Immunization Clinic Parental Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

**A. INFORMATION ABOUT PERSON RECEIVING VACCINE** (PLEASE PRINT)

**Student's Name** Last _____ First _____ Middle _____

Student's Birth Date _____ Age _____ Gender *Male* *Female*

**Parent/Guardian Name** Last _____ First _____ Relationship _____

Student's Address _____ City _____ Zip Code _____

**B. VACCINE ELIGIBILITY SCREENING** (PLEASE CHECK APPROPRIATE BOX)

- ☐ **Medicaid (Package A)** A child, 0 thru 18 years of age, who has Medicaid Package A or Hoosier Healthwise. The parent does not pay a premium for the insurance.
- ☐ **Medicaid (Package C)** A child, 0 thru 18 years of age, who has Medicaid Package C. The parent pays a premium for the insurance.
- ☐ **American Indian/Alaskan Native** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.
- ☐ **No Health Insurance** A child, 0 thru 18 years of age, who does not have health insurance.
- ☐ **Limited Health Insurance** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccine coverage or the parent does not know if the insurance pays for vaccine coverage.
- ☐ **Insured** A child, 0 thru 18 years of age, who has health insurance which provides coverage for vaccines.

**C. VACCINE HEALTH SCREENING** (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time. If you respond 'Yes' to any of the questions, please explain in the space provided.

Yes No 1. Does the student have any allergies to medication, foods, or any vaccines?
Yes No 2. Has the student had a serious reaction to a vaccine in the past?
Yes No 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes No 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?
Yes No 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes No 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes No 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes No 8. Is the student pregnant or is there a chance she could become pregnant during the next month?
Yes No 9. Has the student received vaccinations in the past four (4) weeks?

*Please explain any 'Yes' responses.*_____

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**D. CONSENT TO VACCINATE**

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the Meningococcal, Tetanus, Diphtheria, acellular Pertussis and/or Varicella (Chickenpox) vaccines. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all the apply):

☐ Meningococcal (MCV) ☐ Tetanus, Diphtheria, acellular Pertussis (Tdap) ☐ Varicella (Chickenpox)

I give permission to the Indiana State Department of Health and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

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**E. TO BE COMPLETED BY PERSON ADMINISTERING VACCINE**

| Vaccine | Manufacturer/Lot Number/ Expiration Date | Signature of Vaccinator | Site | Route | Date of VIS |
|---|---|---|---|---|---|
| **MCV4** | | | Left or Right Deltoid | IM | 01-28-08 |
| **Tdap** | | | Left or Right Deltoid | IM | 11-18-08 |
| **Varicella** | | | Left or Right Arm | SC | 03-13-08 |

Entered into CHIRP By _____ Date _____